Data Consortium
Meeting Summary 03-26-09

The Kansas Health Policy Authority (KHPA) hosted the second 2009 (eighth overall) meeting of the Data Consortium on Thursday, March 26th at the Landon State Office Building in Topeka. Twenty-six persons attended, including representatives of 15 member agencies/organizations and other interested parties.

Kansas Health Indicators Document

Dr. Hareesh Mavoori highlighted updates that have been made to the document since it was first made public in January.

- Added state benchmarks, with Iowa as the default state due to its geographic and demographic similarities to Kansas and its high ranking on the Commonwealth State Scorecard.
- Upgraded tables, including counts as well as percentages.
- Live links to the source were added at the bottom of each indicator.
- Refinements to computations and presentations, including:
  - Total hospitalizations - now includes only Kansas residents.
  - % of children enrolled in Medicaid – now broken down by poverty-level-eligible (PLE) age groups.
  - Infant mortality – added 2 years of more recent data from Kansas Information for Communities to the original figures, which were from Kids Count.

KHPA Dashboard was developed, including a subset of indicators of particular interest to the KHPA board. It is anticipated that stakeholders will create their own "views" based on their specific interests.

Dr. Andy Allison pointed out the value of the work that the Data Consortium put into the development of these documents. They are sure to be considered as part of an upcoming evaluation of KHPA.

Discussion points and included:

- Frequency of updates – if the updates will be made as data becomes available and not on a schedule (e.g., quarterly or annually), it will be helpful to include a running log of changes or an indication on each report of the last date changed.
- Note on baselines – one difficulty is that stakeholders may have differing criteria for setting a baseline (KHPA may set 2006, its year of creation, as a baseline; for the Consortium it might by January 2008; others may look at the date of a certain program's implementation as a meaningful baseline).
- Addition of analyses – does that add insight, or bias; who should do it; would the workgroups be able to provide analysis for the reports related to their respective sections? External links to related sites that could provide explanations would be valuable.
- Validation – add a note explaining that the workgroups went through a rigorous process of screening the data sources to assure users that the validity has been verified.
- Tracking use – It was suggested that KHPA gather any statistics available about the number of visits to this document. (Tracking the hits for each indicator is not possible in the current format.)

State Level Data Initiatives

HITECH – On March 19th, KHPA sponsored a meeting to bring together numerous interested parties from the private and public sectors to look at initiatives that might qualify for American Reinvestment and Recovery Act (ARRA) funds. Dr. Barbara Langner, KHPA Policy Director, outlined the advantages of aligning the activities which have already begun in the areas of the Medical Home, Health Information Exchange/Health Information Technology, and Telemedicine/Telehealth as Kansas puts together proposals to leverage the stimulus dollars. The goal is to develop a coordinated plan for programs that will improve health, reduce duplication of services, improve the coordination of care and contain costs.

ARRA offers help in several ways. The lack of interoperability standards has slowed the progress of HIE programs; the federal government will be taking responsibility for developing standards by 2010. ARRA includes policy changes to strengthen federal privacy and security laws to protect from HIIPA violations and offers financial incentives for developing HIT infrastructure and for encouraging doctors and hospitals to use HIE. Eventually, there will be Medicare and Medicaid penalties for non-use. The timeline is very ambitious.

The Federal Medical Assistance Percentage has been increased from 60.08% to 66.28% for Medicaid programs; this requires maintenance of eligibility at the current level. $2 Billion in grants are being made available for HIT systems and expansion of services at Community Health Centers across the nation.

County Dashboard – An overview of a project focusing on county-level health indicators was presented by Dr. Gianfranco Pezzino, Senior Researcher at Kansas Health Institute. Wisconsin led the nation in producing a state-based ranking for all of their counties 6 years ago; other states are following their model. Wisconsin recently received a grant from the Robert Wood Johnson Foundation to produce such rankings for each of the 50 states.

The model assumes that policies and interventions translate to patterns of health determinants, which produce health outcomes. Thirty-one indicators (3 outcomes, 28 determinants) were selected as the basis for the county rankings. (Refer to Diagram of the Project Model and Data Elements with the meeting materials). Many of them were also used for Healthy People 2010 and the Data Consortium's Kansas Health Indicators. A significant sample size was found for all 31 indicators in 26 counties; for at least 20 indicators in 95 counties. For confidentiality, no individual reports were published for counties with too few occurrences of any indicator, but the counts were included in the overall index.

The intent of the project is to stimulate discussion about why certain areas are doing better that others, to help determine the direction a county is moving and ultimately lead to addressing the disparities and sharing plans for intervention. This project may also bring about discussion of how to obtain better data for monitoring the health of our communities.

The report is expected to be released mid-May. The printed report will be relatively short, but will be accompanied by a wealth of supporting data on the web.

Data Analytic Interface (DAI) Update

The major milestone completed since the last meeting is the completion of the data model, integrating the State Employee Health, Kansas Health Insurance, and Medicaid Management Information System systems. The product is expected to go live by the end of the year.

Kansas Health Insurance Information System (KHIIS)

Dr. Mavoori presented an overview of the KHIIS which is managed by KHPA on behalf of the Kansas Insurance Department. It includes health insurance benefit, claims and membership information for Kansas residents enrolled in major commercial group insurance plans. Carriers with more than one percent of the health insurance market in the state submit data. The list, reviewed annually, currently includes 22 companies.

Data collection began in 1995, but that received in earlier years lacks the quality for reliable reporting. Quality controls implemented more recently have improved the accuracy and usability of data for 2006 and later. Development of reports from this dataset, which require express permission from the Insurance Commissioner, has begun. Sample aggregate reports were distributed for review and comment. (Refer to KHIIS reports with the meeting materials.)

Discussion points:

- Why don't the co-pay, co-insurance, deductible and amount paid by insurance carriers equal 100% of allowed amount? One possible explanation is that data related to costs of services that are "over contract limits" (e.g., more days in hospital than allowed) has not been captured, but it will be, beginning this summer. Costs of services on completely denied claims are not captured, so that patient liability is not shown in reports.
- How do these figures compare to other states? To Medicaid? (The DAI will aid with comparisons to Medicaid and the State Employee Health Plan.)
- Since this does not include all insured parties in the state, percentages and ratios are more meaningful than raw numbers.
- It would be helpful to present categories in the same order on all graphs, for comparing one to another.
- There is value in trending information.
- When will this be presented to consumers? What data is useful? How much detail? How often?

- When reports are made public, they should include labeling, caveats, sources and explanations of who is included (not ERISA, self-insured, etc.) so that each one can stand alone.
- The "Mandates Summary" includes data on those services which were most directly identifiable by the procedure or CPT codes – a subset of the complete list of mandates.
- In order for this data to show the impact of a mandate, several years' records would be required, including some pre-mandate years.

Dr. Allison invited suggestions for the types of KHIIS reports they would find useful. Cost sharing, average costs for premiums, trends, and cost of certain diseases were among those offered. Members were encouraged to submit other recommendations to Dr. Mavoori and to offer insight as to the types of consumers who might use this data and what they would want to know.

Next Meeting: May 28, 2009 9:00 am – 12:00 pm.